BEFORE THE DEPARTMENT OF LABOR AND INDUSTRY
STATE OF MONTANA

In the matter of the proposed amendment of ARM 24.29.1401, 24.29.1402, 24.29.1404, 24.29.1415, 24.29.1430, 24.29.1510, 24.29.1517, 24.29.1521, and 24.29.1582, and the adoption of NEW RULES I and II, all related to allowable medical service billing rates for workers' compensation claims	) NOTICE OF PUBLIC HEARING ON PROPOSED AMENDMENT AND ADOPTION

TO: All Concerned Persons

1. On December 7, 2006, at 1:00 p.m., or as soon thereafter as is feasible, the Department of Labor and Industry (department) will hold a public hearing to be held in the first floor conference room (room 104), Walt Sullivan Building, 1327 Lockey Avenue, Helena, Montana to consider the proposed amendment and adoption of the above-stated rules.

2. The substance of this proposal is identical to a proposal made by the department on April 20, 2006, MAR Notice No. 24-29-204, at page 1005 of the 2006 Montana Administrative Register, Issue No. 8. The proposal is being renoticed to cure a procedural error made by the department in the rulemaking process. On May 11, 2006, the department held a public hearing in Helena regarding the above-stated rules. All comments previously made on the proposed amendments and new rules will be considered by the department without the need for the commenter to resubmit those comments. The Final Notice for this proposal will contain the department's responses to all comments made to both notices.

3. The department will make reasonable accommodations for persons with disabilities who wish to participate in this public hearing or need an alternative accessible format of this notice. If you require an accommodation, contact the department no later than 5:00 p.m., on November 30, 2006, to advise us of the nature of the accommodation that you need. Please contact the Employment Relations Division, Workers' Compensation Regulations Bureau, Department of Labor and Industry, Attn: Jeanne Johns, P.O. Box 8011, Helena, MT 59624-8011, telephone (406) 444-7710; fax (406) 444-3465; TDD (406) 444-5549; or e-mail jjohns@mt.gov.

4. The rules proposed to be amended provide as follows, stricken matter interlined, new matter underlined:

<u>24.29.1401 INITIAL LIABILITY</u> (1) and (2) remain the same.

(3) Pursuant to 39-71-743, MCA, when a claim is covered under the Workers' Compensation or Occupational Disease acts, providers may not bill the injured worker for the difference between the initial amount billed and the amount reimbursed to the provider by the insurer as set by applicable statutes and rules, except for the co-pay provided by 39-71-704, MCA.

(a) For injured workers who are receiving benefits from the Uninsured Employers' Fund pursuant to 39-71-503, MCA, the provisions of this rule are subject to 39-71-510, MCA.

~~(3)~~(4) The injured worker is responsible for charges incurred for treatment of conditions which were not the result of the injury or for treatment when medical benefits have terminated according to 39-71-704~~(1) (d)~~, MCA.

AUTH: 39-71-203, MCA
IMP: 39-71-510, 39-71-704, 39-71-743, MCA

REASON: The Workers' Compensation Act (act) is intended in part to function as a statutory system of regulation of the allowable amounts of insurance coverage for a workers' compensation claim. In other words, parts of the act function as a form of managed care to regulate health care costs. Therefore, it is reasonably necessary to clarify that providers may not bill claimants the excess amounts due after the providers are reimbursed by an insurer according to the fee schedule set by these rules and other applicable statutes and rules. Providers may bill for the co-pay provided for in 39-71-704(7), MCA. It is also reasonably necessary to include the language in (3)(a) to provide for the contingency that the Uninsured Employers' Fund ("the UEF") may someday not have sufficient funds to fully pay on claims, and that 39-71-510, MCA, may be applicable, at the same time the rule is otherwise being amended. There is also reasonable necessity to add two statutes to the implementation citation to more fully identify the statutes the rule implements.

24.29.1402 PAYMENT OF MEDICAL CLAIMS (1) through (4) remain the same.

(5) For claims arising before July 1, 1993, no fee or charge ~~shall be~~ is payable by the injured worker for treatment of injuries sustained if liability is accepted by the insurer.

(6) For claims arising on or after July 1, 1993, no fee or charge is payable by the injured worker for treatment of injuries sustained if liability is accepted by the insurer, other than:

(a) the co-payment provided by 39-71-704, MCA. The decision whether to require a co-payment rests with the insurer, not the medical provider. If the insurer does not require a co-payment by the worker, the provider may not charge or bill the worker any fee. The insurer must give enough advance notice to known medical providers that it will require co-payments from a worker so that the provider can make arrangements with the worker to collect the co-payment;

(b) the charges for a nonpreferred provider, after notice is given as provided in 39-71-1102, MCA; ~~or~~

(c) the charges for medical services obtained from other than a managed care organization, once an organization is designated by the insurer as provided in

39-71-1101, MCA; or ~~shall be payable by the injured worker for treatment of injuries sustained if liability is accepted by the insurer. The decision whether to require a co-payment rests with the insurer, not the medical provider. If the insurer does not require a co-payment by the worker, the provider may not charge or bill the worker any fee. The insurer must give enough advance notice to known medical providers that it will require co-payments from a worker so that the provider can make arrangements with the worker to collect the co-payment.~~

(d) the charges for medical services denied by the insurer on the basis that the services meet both of the following criteria:

(i) the medical services do not return the injured worker to employment; and

(ii) the medical services do not sustain medical stability.

(7) For injured workers who are receiving benefits from the Uninsured Employers' Fund pursuant to 39-71-503, MCA, the provisions of this rule are subject to 39-71-510, MCA.

AUTH: 39-71-203, MCA
IMP: 39-71-203, 39-71-510, 39-71-704, MCA

REASON: Hiett v. Missoula County Public Schools, 2003 MT 213, ¶ 35, 317 Mont. 95, 75 P.3d 341, interpreted 39-71-704, MCA, to provide that medical services will be covered by the Workers' Compensation Act if those services are necessary to sustain medical stability, even if the services do not return a worker to employment. Therefore, it is reasonably necessary to incorporate this precedent into the rule in order to clarify when an injured worker is responsible for payment of medical care pursuant to 39-71-704, MCA. Because Hiett interpreted language that became effective on July 1, 1993, and that still exists in statute today, it is appropriate to indicate this rule change applies to all claims after July 1, 1993.

It is also reasonably necessary to clarify that for any injured workers receiving benefits from the UEF, any requirements in the rule are subject to the statutory provisions that govern the UEF. Specifically, if the UEF reduces benefits payments to prorated amounts as provided by 39-71-510, MCA, it is possible that claimants may be liable to medical providers for the difference between the amount paid by the UEF and the amount allowed under the fee schedule. So as not to mislead readers, the proposed rule clarifies that it is subject to 39-71-510, MCA. Finally, it is necessary to amend the rule to make it easier to read for users.

24.29.1404 DISPUTED MEDICAL CLAIMS (1) Disputes arising over the following issues are resolved by a hearing before the department upon written application of a party to the dispute or the injured worker:

(a) ~~Amounts~~ amounts payable to medical providers, when benefits available directly to claimants are not an issue~~,~~;

(b) ~~Access~~ access to medical records~~,~~;

(c) ~~Timeliness~~ timeliness of payments to medical providers~~.~~; or

(d) requirements for documentation submitted by a provider to an insurer pursuant to ARM 24.29.1513 as a condition of the payment of medical fees.

(2) All other disputes arising over medical claims, including travel expense reimbursement to injured workers, shall be brought before a department mediator as provided in part 24 of the Workers' Compensation Act.

(2) and (3) remain the same, but are renumbered (3) and (4).

AUTH: 39-71-203, MCA
IMP: 39-71-203, 39-71-704, MCA

REASON: It is reasonably necessary to clarify the disputes that must be resolved by a hearing rather than mediation, pursuant to 39-71-704(6), MCA. Specifically, disputes between insurers and medical providers related to medical service fees and concerning documentation requirements or disallowed procedures must go to hearing rather than mediation. There is also reasonable necessity to make technical corrections in earmarking, capitalization, and punctuation matters while the rule is otherwise being amended.

24.29.1415 IMPAIRMENT RATING DISPUTE PROCEDURE (1) This section applies to dates of injury beginning July 1, 1987, through June 30, 1991. An evaluator must be a qualified physician licensed to practice in the state of Montana under Title 37, chapter 3, MCA, and board certified ~~or board eligible~~ in ~~his~~ an area of specialty appropriate to the injury of the claimant, except that if the claimant's treating physician is a chiropractor, the evaluator may be a chiropractor who is certified as an impairment evaluator under Title 37, chapter 12, MCA. The claimant's treating physician may not be one of the evaluators to whom the claimant is directed by the department.

(2) remains the same.

(3) The department shall give written notice to the parties of the time and place of the examination. If the claimant fails to give 48 hours notice of ~~his~~ the claimant's inability to attend the examination, ~~he~~ the claimant is liable for payment of the evaluator's charges.

(4) and (5) remain the same.

(6) The impairment evaluators shall operate according to the following procedures:

(a) The evaluator shall submit a report of ~~his~~ the evaluator's findings to the department, claimant, and insurer within 15 days of the date of the examination.

(b) remains the same.

(c) The second evaluator shall submit a report of ~~his~~ the second evaluator's findings to the department, claimant, and insurer, within 15 days of the date of the examination.

(d) through (f) remain the same.

AUTH: 39-71-203, MCA
IMP: 39-71-711, MCA

REASON: It is reasonably necessary to delete the "board eligible" qualification because the department has recently been advised the term is no longer used within

the medical profession. It is also reasonably necessary to make the rule gender neutral while the rule is otherwise being amended.

24.29.1430 HOSPITAL RATES ~~BEGINNING~~ FROM JULY 1, 1998, THROUGH JUNE 30, 2001 (1) through (3) remain the same.

AUTH: 39-71-203, MCA
IMP: 39-71-704, MCA

REASON: It is reasonably necessary to amend the catchphrase of this rule due to proposed New Rule I, discussed below.

24.29.1510 SELECTION OF PHYSICIAN FOR CLAIMS ARISING ON OR AFTER JULY 1, 1993 (1) For claims arising on or after July 1, 1993, "treating physician" has the meaning provided by 39-71-116~~(29)~~, MCA ~~(1993)~~.

(2) remains the same.

(3) Selection of the treating physician, referrals made by the treating physician, and changes of treating physician must all be made in accordance with the provisions of 39-71-1101, MCA ~~(1993)~~. Treatment from a physician's assistant or an advanced practice nurse, when the treatment is under the direction of the treating physician, does not constitute a change of physician and does not require prior authorization pursuant to ARM 24.29.1517.

(4) Subject to 39-71-1101, MCA, ARM 24.29.1517, and any other applicable rule or statute, nothing in this rule prohibits the claimant from receiving treatment from more than one physician if required by the claimant's injury or occupational disease.

AUTH: 39-71-203, MCA
IMP: 39-71-704, MCA

REASON: It is reasonably necessary to amend (1) to delete the reference to (29) because statutory changes have caused renumbering of the reference. It is also reasonably necessary to delete the reference to the year 1993 in (3) because the later versions of the statute are applicable to later claims.

In addition, Anderson v. Albertson's, Inc., 2004 MT WCC 59, WCC No. 2004-1058, held that 39-71-704, MCA, does not limit the number of physicians who can treat a claimant. Therefore, it is reasonably necessary to indicate that a claimant may receive treatment from as many physicians as required by their injury or occupational disease.

Also, Travelers Property Casualty v. Martini, 2002 MT WCC 31, held that prior authorization is not required for treatment by an advance practice nurse employed by the treating physician when the treating physician is still primarily responsible for the claimant's treatment. Therefore, it is reasonably necessary to clarify that treatment by a physician's assistant or advance practice nurse under the direction of the treating physician does not require prior authorization.

24.29.1517 PRIOR AUTHORIZATION (1) When prior authorization is required as provided by (4), the provider must request the authorization a reasonable amount of time in advance of the time the procedure is scheduled to be performed. The request must contain enough information to allow the insurer to make an informed decision regarding authorization. The insurer may not unreasonably withhold its authorization. An ~~insurers'~~ insurer's denial must contain an explanation of the reasons for its denial. Reasonableness will be judged in light of the circumstances surrounding the medical procedure and the claim.

(2) through (6) remain the same.

(7) If medical services related to the injury or occupational disease are denied pursuant to this rule because a provider failed to try to obtain prior authorization, an injured worker cannot be billed for those denied medical services pursuant to 39-71-743, MCA.

(8) When an insurer denies liability for an injury or occupational disease, and the insurer then later assumes liability for a particular condition, the insurer may not deny payment for the medical services provided for that condition during the period of denial based solely on failure to obtain prior authorization.

AUTH: 39-71-203, MCA
IMP: 39-71-704, 39-71-743, MCA

REASON: It is reasonably necessary to amend this rule to clarify that an injured worker cannot be excess billed for medical services if the medical provider does not obtain prior authorization pursuant to this rule. This proposed change is a specific clarification in addition to the proposed change to ARM 24.29.1401 discussed above.

Further, the department has become aware of situations in which an insurer initially denies liability for an injury, then when the insurer later assumes liability for the injury, but the insurer denies past treatment due to the provider's failure to obtain prior authorization. Because it is impossible for a provider to obtain prior authorization for a specific procedure or treatment when an insurer denies all liability for a claim, the department believes it is reasonably necessary to clarify the rule. Specifically, when an insurer later assumes liability for a particular condition, the proposed amendments provide that the insurer also assumes liability for any medical services that were denied pursuant to this rule. It is also reasonably necessary to add the internal cross-reference to make the rule clearer for the reader and to correct the typographical error, and also to add the reference to 39-71-743, MCA, as an implemented statute.

24.29.1521 MEDICAL EQUIPMENT AND SUPPLIES (1) Reimbursement for ~~provider supplied~~ medical equipment and supplies dispensed through a medical provider is limited to the lesser of $30.00 or 30% above the cost of the item including freight, except prescription medicines are limited to charges allowed under 39-71-727, MCA. An invoice documenting the cost of the equipment or supply must be sent to the insurer upon the insurer's request.

(2) remains the same.
(3) This rule does not apply to:
(a) equipment supply houses that are not also health care providers~~,~~;
(b) hospitals~~,~~; or
(c) pharmacies.

AUTH: 39-71-203, MCA
IMP: 39-71-704, MCA

REASON: It is reasonably necessary to clarify reimbursement of medical supplies dispensed by a medical provider because the former wording proved confusing for readers of the rule. It is also reasonably necessary to set out (earmark) the subsections of (3) for clarity.

24.29.1582 PROVIDER FEES--OCCUPATIONAL AND PHYSICAL THERAPY SPECIALTY AREA FOR SERVICES PROVIDED ~~ON OR AFTER~~ FROM JULY 1, 2002, THROUGH SEPTEMBER 30, 2003 (1) through (8) remain the same.

AUTH: 39-71-203, MCA
IMP: 39-71-704, MCA

REASON: It is reasonably necessary to amend the catchphrase of this rule due to proposed New Rule II, discussed below.

5. The proposed new rules provide as follows:

NEW RULE I HOSPITAL RATES BEGINNING JULY 1, 2001 (1) Any hospital, other than one licensed as a medical assistance facility or critical access hospital under Title 50, chapter 5, MCA, that changes its usual and customary charges on or after July 1, 2001, must have its rates adjusted by the use of a discount factor. The discount factor is computed by taking the existing discount factor for that hospital, divided by the quantity 1 + ORI, where ORI is the overall percentage rate change adopted by the hospital, divided by 100.

(2) For hospital services rendered by a hospital not licensed as a medical assistance facility or critical access hospital under Title 50, chapter 5, MCA, the amount payable by an insurer for those services performed during the fiscal year starting July 1, 2001, is that hospital's discount factor in effect on June 30, 2001, plus the percentage increase in the state's average weekly wage. The adjusted discount factor is computed by multiplying the existing discount factor for that hospital times (1 + the percentage increase).

(3) The department will thereafter recalculate each hospital's discount factor to take into account changes to the hospital's usual and customary charges. The department will also annually recalculate, effective July 1 of each year, each hospital's discount factor to take into account the percentage increase in the state's average weekly wages made during the previous calendar year. If for any year the

state's average weekly wage does not increase, the rates will be held at the existing level until there is a net increase in the state's average weekly wage.

AUTH: 39-71-203, MCA
IMP: 39-71-704, MCA

REASON: Chapter 192, L. of 2001 (Senate Bill 194), added critical access hospitals to the facilities with rates designated by 39-71-704(3)(g), MCA. It is reasonably necessary to conform the hospital rate rules to the statute by adding critical access hospitals to the language of the rules. Proposed New Rule I copies the text of the rule for the previous time period, ARM 24.29.1430, adds critical access hospitals to medical assistance facilities as required by 39-71-704(3)(g), MCA, and updates the date used for the effective date of the discount factor. It is reasonably necessary to adopt New Rule I rather than amend ARM 24.29.1430 because all the users of these rules are accustomed to rules that are set out by time period, and because providers have requested a specific rule on the matter, rather than mere reference to the applicable statute.

NEW RULE II PROVIDER FEES--OCCUPATIONAL AND PHYSICAL THERAPY SPECIALTY AREA FOR SERVICES PROVIDED ON OR AFTER OCTOBER 1, 2003 (1) Fees for services provided by occupational therapists and physical therapists are payable only for the procedure codes listed below, and unless otherwise specified are payable according to the unit values listed in the RVP.

(2) Nothing in this rule is to be construed so as to broaden the scope of a provider's practice. Each provider is to limit services to those that can be performed within the limits and restrictions of the provider's professional licensure. Providers may only charge for services performed that are consistent with the scope of their practice and licensure.

(3) Except as provided by (6), the conversion factor used depends on the date the service was rendered:

(a) Effective July 1, 2002, the conversion factor for services performed by a licensed occupational therapist, or a licensed physical therapist within their scope of practice, is set at $4.25.

(b) Beginning January 1, 2003, the conversion factor will be adjusted in the manner specified by ARM 24.29.1536.

(4) Only the following codes found in the RVP may be billed for services provided by occupational therapists and physical therapists:

(a) All physical medicine and rehabilitation codes, except 97770 through 97781, may be billed. Code 97799 may be billed only for providing the following services and requires a separate written report describing the service provided when billing for this code:

(i) face-to-face conferences with payor representative(s) to update the status of a patient upon request of the payor;

(ii) a report associated with nonphysician conferences required by the payor; or

(iii) completion of a job description or job analysis form requested by the payor.

(b) Special services, procedures, and report codes 99070 and 99080 Nt bw billed. A separate written report must be submitted describing the service provided when billing for these codes.

(5) The explanations, protocols, comments, and directions for use contained in both the CPT manual and the RVP are to be applied to the procedure codes contained in this rule.

(6) Effective July 1, 2002, code 97750 is payable at $26.50 per 15-minute unit for a maximum of 24 15-minute increments of service per day. Beginning January 1, 2003, and each year annually thereafter, the amount payable per 15-minute unit for code 97750 shall increase by the percentage increase in the state's annual average weekly wage. If for any year the state's average weekly wage does not increase, the rate will be held at the existing level until there is a net increase in the state's average weekly wage.

(7) When physical or occupational therapists are billing code 97033 (iontophoresis), medication charges and electrode charges must each be billed separately for each visit using CPT code 99070.

(8) When occupational therapists or physical therapists are performing orthotics fitting and training (code 97504) or checking for orthotic/prosthetic use (code 97703), supplies and materials provided may be billed separately for each visit using CPT code 99070.

AUTH: 39-71-203, MCA
IMP: 39-71-704, MCA

REASON: Chapter 101, L. of 2003 (House Bill 542) allows occupational therapists to perform iontophoresis. It is reasonably necessary to amend the provider fee rule for physical and occupational therapists to clarify that occupational therapists may now bill for iontophoresis under procedure code 97033. Chapter 101 became effective on October 1, 2003. Proposed New Rule II copies the text of the rule for the previous time period, ARM 24.29.1582, and amends (4) and (7) in order to add iontophoresis to the procedures billable by occupational therapists. It is reasonably necessary to adopt New Rule II rather than amend ARM 24.29.1582 because all the users of these rules are accustomed to rules that are set out by time period, and because providers have requested a specific rule on the matter, rather than mere reference to the applicable statute.

6. Concerned persons may present their data, views, or arguments, either orally or in writing, at the hearing. Written data, views, or arguments may also be submitted to: Jeanne Johns, Workers' Compensation Regulations Bureau, Employment Relations Division, Department of Labor and Industry, P.O. Box 8011, Helena, Montana 59624-8011; by facsimile to (406) 444-3465; or by e-mail to jjohns@mt.gov, and must be received by no later than 5:00 p.m., December 14, 2006.

7. An electronic copy of this Notice of Proposed Amendment and Adoption is available through the department's web site at http://dli.mt.gov/events/calendar.asp, under the Calendar of Events, Administrative Rules Hearings section. The department strives to make the electronic copy of this Notice conform to the official version of the Notice, as printed in the Montana Administrative Register, but advises all concerned persons that in the event of a discrepancy between the official printed text of the Notice and the electronic version of the Notice, only the official printed text will be considered. In addition, although the department strives to keep its web site accessible at all times, concerned persons should be aware that the web site may be unavailable during some periods, due to system maintenance or technical problems, and that a person's difficulties in sending an e-mail do not excuse late submission of comments.

8. The department maintains lists of interested persons who wish to receive notices of rulemaking actions proposed by this agency. Persons who wish to have their name added to the mailing lists shall make a written request which includes the name and mailing address of the person to receive notices and specifies that the person wishes to receive notices regarding all Department of Labor and Industry administrative rulemaking proceedings or other administrative proceedings. Such written requests may be mailed to the Department of Labor and Industry, attention: Mark Cadwallader, 1327 Lockey St., Room 412, Helena, Montana, mailed to Mark Cadwallader, P.O. Box 1728, Helena, MT 59624-1728, faxed to the office at (406) 444-1394, e-mailed to mcadwallader@mt.gov, or may be made by completing a request form at any rules hearing held by the agency.

9. The bill sponsor notice requirements of 2-4-302, MCA, do not apply.

10. The department's Hearings Bureau has been designated to preside over and conduct this hearing.

/s/ MARK CADWALLADER
Mark Cadwallader
Alternate Rule Reviewer

/s/ KEITH KELLY
Keith Kelly, Commissioner
DEPARTMENT OF LABOR AND INDUSTRY

Certified to the Secretary of State October 30, 2006